# INCIDENT REPORT AND REVIEW FORM

**INVOLVED EMPLOYEE INFORMATION**

Name: _____ Incident Date: _____

Job Title: _____ Credentials: _____

**INVOLVED CLIENT INFORMATION**

Name: _____ Incident Date: _____

Treatment Coordinator: _____

**TYPE OF INCIDENT:**

- ☐ Client injury (accidental or otherwise)
- ☐ Client injury or attempted injury of another client
- ☐ Medication error
- ☐ Client injury or attempted injury by Center staff
- ☐ Damage to public or private property
- ☐ Threat of injury by client, non-client, or staff
- ☐ Potential infectious disease exposure
- ☐ Violation of Workplace Safety/Weapons Policy
- ☐ Other _____

☐ **Staff Injury** - Contact Director of HR to complete the Worker's Compensation First Report of Injury. A copy will be attached to this report and forwarded for Executive and/or Safety Committee review.

☐ **Staff Injury** - **report to OSHA** within 24 hours if injury resulted in hospitalization, amputation (loss of flesh with/without bone), or loss of an eye.
Notify Director of HR (435-512-3902). IF NOT AVAILABLE, CALL OSHA.
**Reported to OSHA** 801-530-6901: Date _____ Time _____ **Reported to Worker's Comp**: Date _____ Time _____

☐ **Staff Fatality** - **report to OSHA** within 8 hours.
Notify Director of HR (435-512-3902). IF NOT AVAILABLE, CALL OSHA.
**Reported to OSHA** 801-530-6901: Date _____ Time _____ **Reported to Worker's Comp**: Date _____ Time _____

☐ **Vehicle Accident** - For Center-related vehicle accidents, the vehicle driver must complete a drug screen at Logan Regional Hospital or Bear River Valley Hospital in Tremonton, immediately following the accident.

**DESCRIBE THE INCIDENT, HOW IT OCCURRED, AND INCLUDE ANY APPARENT ROOT CAUSES** (Be Specific - attach supplemental pages as necessary):

**CORRECTIVE ACTIONS TAKEN TO RESOLVE THE INCIDENT:**

Reception staff notified if incident involved a volatile client: ☐ YES ☐ NO

Staff Signature _____ Date _____

## SUPERVISORY REVIEW

**CONTRIBUTING FACTORS:** (Please review the above incident as to the following elements)

| | | | | | |
|---|---|---|---|---|---|
| Actions | ☐ Failure to follow policy/training | ☐ Horseplay | ☐ Operating equipment without authority | ☐ Bypassing safety device | |
| | ☐ Inattentiveness | ☐ Unsafe acts of others | ☐ Servicing equipment while in use | ☐ Using defective equipment | ☐ Other: |
| | ☐ Safety rule violation | ☐ Improper lifting | ☐ Using equipment or PPE improperly | ☐ Under the influence | |
| Conditions | ☐ Poor workstation design or layout | ☐ Congested work environment | ☐ Hazardous substance present | ☐ Fire or explosion hazard | ☐ Restricted motion |
| | ☐ Insufficient guards / safety interlocks | ☐ Improper tool or equipment used | ☐ Excessive noise | ☐ High or low tempertures | ☐ Other: |
| | ☐ Defective tools/equipment/materials | ☐ Poor house keeping | ☐ Inadequate lighting / ventilation | ☐ Wet or slippery conditions | |
| Management | ☐ Lack of written procedure | ☐ Rules not enforced | ☐ Inadequate supervisor training | ☐ Hazards not identified | |
| | ☐ Inexperience of employee | ☐ Insufficient maintenance | ☐ Insufficient supervision | ☐ Unsafe design (engineering) | ☐ Other: |
| | ☐ Inadequate work standards | ☐ Unrealistic scheduling | ☐ Insufficient worker training | | |

**ESTIMATED POSSIBILITY OF INCIDENT RE-OCCURRING:** ☐ High ☐ Moderately High ☐ Average ☐ Low ☐ Unlikely

**IDENTIFY THE INJURY RESULTING FROM THE INCIDENT (IF APPLICABLE):** ☐ N/A ☐ Other: _____

- ☐ Cut / Laceration
- ☐ Puncture Wound
- ☐ Chemical Inhalation
- ☐ Chemical Burn
- ☐ Physical Exhaustion
- ☐ Dislocation
- ☐ Compound Fracture
- ☐ Sprain / Strain
- ☐ Heat / Cold Burns
- ☐ Heat / Cold Stress
- ☐ Chemical Irritation
- ☐ Contusion / Bruise
- ☐ Electrical Shock
- ☐ Foreign Body
- ☐ Stress Fracture

**FIRST AID OR MEDICAL Tx PROVIDED:** ☐ YES ☐ NO Specify: _____

ER Treatment: ☐ YES ☐ NO Hospitalization: ☐ YES ☐ NO Facility: _____ Date Admitted: _____

**ADDITIONAL INFORMATION NOT INCLUDED ABOVE:**

Supervisor Signature _____ Date _____

## EXECUTIVE COMMITTEE REVIEW

☐ Incident resolved ☐ Further follow-up needed ☐ Incident Review Committee Appointed ☐ Incident forwarded to Safety Committee for review and action

EC Signature _____ Date _____

## SAFETY COMMITTEE REVIEW

Safety Committee Signature _____ Date _____

Revised 2/2016